#113 Meeting Summary
May 29, 2009

Virginia HIV Community Planning Group
Meeting Summary

Members Present: Odile Attiglah, Melissa Baker, Shimeles Bekele, Bill Briggs, Rhonda Callaham, Rosalyn Cousar, Hugo Delgado, Pierre Diaz, Gregory Fordham, Caroline Fuller, Janet Hall, Richard Hall, Robert Hewitt, Cheryl Hoffman, Mike King, Martha Lees, Elaine Martin, Nicholas Mattsson, Shawn McNulty, Rachel Rees, Ruth Royster, Thomas Salyer, Edward Strickler, Bruce Taylor, Adam Thompson, Silvia Villacampa, Donald Walker, Shannon Young

Members Absent: Vontrida Custis (represented)

Other Attendees: Ayana Andrews-Joseph, Susan Carr, Kathleen Carter, Jennifer Flannagan, Diana Jordan, Christopher Lane, Phyllis Morris and Shelley Taylor-Donahue of the Virginia Department of Health; Justine Annis (representing Vontrida Custis)

Total of 37 attendees

Welcome and Introductions – Elaine Martin, Health Department Co-Chair
The meeting was called to order at 9:00 AM.

Membership

- ★ This was the first joint care and prevention meeting and 12 new members were welcomed: Melissa Baker, Shimeles Bekele, Pierre Diaz, Janet Hall, Cheryl Hoffman, Mike King, Shawn McNulty, Rachel Rees, Thomas Salyer, Adam Thompson, Donald Walker and Shannon Young.
- ★ 2009 VDH Nominees to the Statewide Governor's Awards Competition – Rick Hall has been nominated for his innovative and forceful leadership in improving the quality and delivery of care to HIV/AIDS patients in the Three Rivers Health District. His success has earned national recognition for Virginia as a model for more than 300 safety net providers from Puerto Rico to Hawaii. Congratulations, Rick!
- ★ Elaine Martin indicated that state agency representation is low right now; that will be a focus to regain some of those partnerships that have been lost over the years.

What to Expect from the First Meeting and as a Member/Testimonials from Current Members Gregg Fordham, Dr. Rosalyn Cousar, and Ruth Royster shared their personal experiences as a CPG member.

What is Community Planning? - Jennifer Flannagan, Community Planner
Community planning is a process in which people with different life experiences come together to plan how to prevent and treat HIV infections in their communities. It is a collaborative effort between VDH and the community; its members are representative of the HIV/AIDS epidemic and persons living with HIV are an integral part of membership. The CPG is charged with designing local HIV service plans that best represent the needs of communities at risk for or already infected with HIV.

History, Purpose, PIR, Guiding Principles, Member Roles & Expectations - Elaine Martin
As mandated by Congress, the state community planning process was implemented in 1994. At that time, priority setting and selection of populations and interventions moved to the local community level rather than the federal government. The main tenets of the CPG are parity, inclusion, and representation: Parity means that all members have the ability to participate, make decisions and carry out planning tasks. Inclusion means that members have a meaningful involvement in the community planning process with an active voice in decision making. And finally, representation means that members should represent the perspectives of the affected communities - their values, beliefs and behaviors - and members need to be willing to speak up to represent their communities.

Listed below are the guiding principles by which the CPG operates. The group's research, recommendations and plans are guided by these principles:

<u>Health Education</u>

- Behavior that is healthy or risky can be objectively established by scientific investigation. The health practices of an individual remain a personal decision and responsibility (taking into consideration the individual's competency).
- Comprehensive and sequential health education must go beyond the transmission of information. Behavioral changes result only when information is supported by shared values that are strongly conveyed and consistently reinforced.
- Health educators should provide comprehensive, accurate information about the consequences of behavioral choices and ways to eliminate and/or reduce the risks associated with those choices.
- Effective health promotion programs are persistent, persuasive and sustained, going beyond a one-shot approach.
- Effective health education derives from many important sources: family, school, peer groups, the neighborhood, religious organizations, the workplace, commercial media, the unique leadership within each community and others.

- Everyone needs the opportunity to practice skills necessary to make behavioral changes. Support from others is important to adopt and sustain behavioral choices and/or changes.
- Funding decisions should be needs-based and should consider cost-effectiveness, with funds being invested in programs that will demonstrate effectiveness based on evaluation.

HIV

- Persons affected by HIV disease should have protection of confidentiality and freedom from discrimination.
- The most effective way to prevent HIV is abstinence from behaviors that place persons at risk. Health educators should provide support and skills for abstinence from these behaviors.
- Persons who engage in behaviors that place them at risk for HIV should be provided with a range of risk reduction options.
- HIV prevention efforts rest on the same principles used in attempts to deter other behaviors that adversely affect health, such as reckless or drunken driving, cigarette smoking, substance abuse, poor nutritional habits, lack of exercise and obesity.
- Plans and curricula for HIV prevention education should be appropriately designed based on the age, gender, ethnicity, culture, sexual orientation, literacy, language and other important features of the populations to be served.
- Responding to the HIV epidemic requires a public and private partnership. VDH and its local health departments share this responsibility with other state and local agencies, private and community-based organizations, private hospitals, health care providers, affected communities and volunteers.

Roles of CPG members:

- Commit to participate in decision making, sometimes making difficult choices, especially regarding limited CPG funding
- Review epidemiologic and scientific data
- Set priorities among needs and interventions
- Serve on ad hoc committees
- Contribute to development of service plans
- Evaluate the planning process
- Assess the health department's responsiveness
- Develop an agenda based on input from members
- Facilitate participation and proper orientation of all members
- Determine shared responsibilities
- Review minutes
- Manage conflicts
- Represent the sentiments of CPG members regarding concurrence (related to CDC grant application)

Role of VDH staff:

- Provide leadership and support; ensure clear understanding of roles
- Furnish technical data, assist with needs assessment, allocate funds based on priorities
- Draft comprehensive work plan, manage meeting logistics, disseminate materials

How to increase your CPG success:

- Take information back to the community you represent or serve
- Understand the community you represent
- Be committed and collaborative

Elaine concluded her presentation with a discussion concerning how the HIV prevention plan is linked to the CDC HIV prevention grant which VDH applies for each year.

"Safe in the City" Video

Currently, 25 STD clinics in Virginia are using this educational tool. The video is available free of charge from CDC. Educational materials are included and can be ordered at www.effectiveinterventions.org.

History and Achievements of the CPG in Virginia - Elaine Martin

- ★ African-American Faith Initiative began in January 1, 1999 - CPG worked with African American churches, did focus groups and funded a pilot project.
- ★ Created the MSM HIV Prevention grant program – increased focus on that population – funding eventually went up to 30% (started at 3%)
- ★ Primary Prevention for Positives – 2001 - # 1 priority population designated by CDC; however, CPG was way ahead of CDC in identifying this population.
- ★ Transgender Survey – groundbreaking work which has culminated in projects at Fan Free Clinic in Richmond and ACCESS in Norfolk; both offer clinical services and hormones to this population with positivity rates between 15-20%.
- ★ Street Outreach training - an outgrowth of CPG

Virginia HIV Community Planning Group - Jennifer Flannagan

Jennifer read the mission statement of the CPG. Jennifer listed proposed changes to the revised bylaws and a motion was made and seconded to accept the revisions; the vote was unanimous. Jennifer then reported on the conference call held with members on May 18th concerning the issue of having two co-chairs, one for prevention and one for care. The consensus reached is to have Dr. Rosalyn Cousar continue in her role as community co-chair one

more year. In 2010, an election will be held for the community co-chair position. Membership of the CPG shall consist of no less than 25 members and no more than 35 (current membership is 29). Elaine reported the timeline for the Comprehensive Plan, how VDH will spend CDC's funding and that the CPG is charged with seeing if VDH is spending the money effectively. This is done by writing a letter of concurrence or non-concurrence each year.

HIV Care System in Virginia overview - Shelley Taylor-Donahue, HIV Services Planner

- ✓ People living with HIV/AIDS have several options for accessing medical care and other services in Virginia: academic medical centers (e.g., UVA, MCV), community-based organizations, community health centers, hospitals, private medical practices, public health clinics.
- ✓ People living with HIV/AIDS in Virginia generally access care using: indigent care funds, Medicaid, Medicare, private insurance, Ryan White funds, or self-pay.
- ✓ Ryan White services are available in every part of the state.
- ✓ Distribution of Ryan White funding: 75% of funds for Parts A, B, and C must be spent on core medical services – the remaining can be spent on other supportive services.
- ✓ There are five Ryan White Part B consortia in Virginia tasked with:
  > conducting a needs assessment
  > developing a strategic plan and setting servicing priorities
  > promoting coordination and integration of community resources
  > assuring the provision of comprehensive outpatient health and support services
  > evaluating the success and cost effectiveness of the consortium
- ✓ VDH Service planning:
  > ADAP Advisory Committee – advises HIV Care Services on changes to the Formulary, eligibility criteria, adherence issues and educational concerns
  > Public Hearings – obtain feedback from the community concerning service provision
  > Focus Groups – obtain feedback from providers and consumers
- ✓ VDH Service Evaluation:
  > Peer Review Team – perform site visits to service providers to evaluate quality of client care
  > Quality Management Activities include Cross Part Collaborative, Patient Safety Clinical Pharmacy Collaborative, Ryan White Quality Management Advisory Committee

Young Black MSM Advisory Committee Update - Christopher Lane, Project Coordinator

Mr. Lane reported that the advisory group has been meeting via teleconference to find out what's going on with African-American MSM, age 16-24, in Virginia. Mr. Lane has developed a brief survey (14 questions) to obtain the following data from the population: age; how they identify; residence; educational background; who they live with; knowledge of behavior (what they know about HIV); do they know where to go to get tested; who they are having sex with; what kind of sex are they having; where are they meeting (bars? on-line?); if on-line, what web sites are they using; have they ever been tested for HIV and if not, why; have they been tested for other things, e.g. STIs; and what kinds of drugs they're using. A face-to-face meeting is scheduled for June 9 at Fan Free Clinic in Richmond. At that meeting, the survey will be finalized and the group will decide how it will be disseminated. Elaine explained that the survey is important because this is the fastest growing HIV+ population in Virginia. She asked members interested in serving on the advisory committee to contact Jennifer Flannagan at jennifer.flannagan@vdh.virginia.gov or (804) 864-8015.

HIV Prevention in Virginia Overview - Jennifer Flannagan

Jennifer explained that DDP's HIV Prevention Program is funded primarily through a cooperative agreement with CDC. The ensuing grants support a range of activities and are listed below:

- African American Faith Initiative (AAFI)
- AIDS Services and Education (ASE)
- Comprehensive HIV/AIDS Resources & Linkages for Inmates (CHARLI)
- High Risk Youth and Adult (HYRA)
- Minority AIDS Projects (MAP)
- Men who have Sex with Men (MSM)
- Primary Prevention with People Living with HIV (P4P)

Expanded HIV Testing

In 2007, VDH was awarded funds to expand HIV testing to populations disproportionately affected by HIV. Targeted venues include: emergency hospital rooms, community health centers, correctional facilities, substance abuse treatment centers, and community-based organizations. Expanded HIV Testing Grant funds also provide rapid testing kits for the CHARLI grant program.

Disclosure Assistance Services

If an individual is diagnosed with HIV or certain sexually transmitted diseases, Disclosure Assistance is a process by which sex and/or needle sharing partners are notified that they may have been exposed to an infection and need to be tested.

State Funded Grants

- ASE – very limited funding; intended to support outreach, innovative prevention interventions for hard to reach populations and supportive services for persons living with HIV.
- CHARLI - recent collaborative effort between HIV care and prevention which will expand upon current efforts such as the Seamless Transition Program; Elaine reported that a ranking panel will meet next week for proposals from the Southwest region.

Public Information

- Virginia HIV/STD/Viral Hepatitis Hotline – provides statewide toll-free lines staffed by trained counselors to answer questions and provide crisis intervention, referrals and educational materials regarding STDs, HIV/AIDS and viral hepatitis. The Hotline also provides information pamphlets, brochures, posters, etc.
- Foto Novella
- Awareness Days and Campaigns
  - Black HIV Awareness Day (February 7)
  - National HIV Testing Day (June 27)
  - National Latino HIV Awareness Day (October 15)
  - World AIDS Day (December 1)
  - CDC's *9 ½ Minutes* Campaign
  - Syphilis Elimination Campaign
- PEMS (Program Evaluation and Monitoring System) – A secure Internet browser-based software program consisting of standardized data variables for data entry, collecting and reporting for HIV prevention programs; all contractors are required to participate. Elaine introduced Ayana Andrews-Joseph as new PEMS coordinator.

Training/Capacity Building

Training in the following areas is offered periodically:

- Core Strategies for Street and Community Outreach
- SISTA (Sisters Informing Sisters About Topics on AIDS)
- Healthy Relationships
- VOICES (Video Opportunities for Innovative Condom Education and Safer Sex)
- Grant Writing
- Board Development
- Fiscal Management
- Taking Care of Self While Taking Care of Others
- Transgender Health
- Faith-based initiatives
- Comprehensive HIV Educator training

Contract Monitors

- ★ VDH contract monitors serve as the first point of contact within DDP regarding contractual matters.
- ★ Contract monitors address questions/concerns and provide technical assistance.

Summary of Benefits of Integrating Care and Prevention - Jennifer Flannagan
A summary follows of the benefits and barriers of combining care and prevention planning bodies identified at the June 20, 2008 CPG meeting:

---Benefits of combining prevention and care planning bodies

- One stop shopping-unified vision; customer benefits
- Statewide uniformity
- Increased representation of risk populations
- More creative ways to use money(solutions, efficiency, streamline)
- Subcommittees may be more effective
- Overlap of services
- Joint mission/vision
- Diversity
- More consumer voice
- Universal understanding of consumers
- Higher understanding of knowledge and skills-more expertise
- Decrease number of meetings, paperwork for providers/contractors
- Increase linkage of prevention and care(P4P)
- Decrease of "us vs. them"
- Change will happen faster, jointly, more efficient
- Better resources to find out of care

Barriers of combining prevention and care planning bodies

- Increase representation of risk
- Larger committee
- Member expertise-may either be completely prevention or care
- Some areas may be more represented than others
- Less access to youth
- Fear of loss of autonomy
- More negative clinical (providers) input
- Too expensive
- Reservations to change, "turf-ism", territorial
- Potential to repeat past mistakes
- Care people taking over-focused only on care
- Workload increase
- Needs for each locality addressed
- Budget
- Initial reaction to consortia
- Regional representation stacked up in some areas, low in others i.e. Southwest Virginia

Review of the April meeting summary
Motion was made and seconded to approve the minutes as written.

Adjournment
The regular meeting adjourned at 3:30 pm. New members stayed afterwards to complete and sign new member forms.

Elaine Martin, Health Department Co-Chair Date

Kathleen Carter, Recording Secretary Date